CODE	Section VII	MARKETING	YES	NO	NOTE
	MARKETING ACTIVITIES **As Applicable, use Worksheets WS-MK1, WS-MK2 and WS-MK3**				
MK01	**The MCO offers its benefit plan to all Medicare-beneficiaries and provides prospective enrollees adequate written descriptions of its rules, procedures, benefits, fees and other charges, services, and other necessary information for the beneficiary to make an informed decision about enrollment.** **42 CFR 417.428(a)(1); National Marketing Guidelines**	**[ ] MET [ ] NOT MET**			
MK01a	**The MCO charges Medicare members only for (1) deductible and coinsurance amounts (as described in 42 CFR 417.452(a)) for furnished covered services, (2) noncovered services or services for which the enrollee is liable (as described in 42 CFR 417.452(b)), and (3) services for which Medicare is not the primary payer (as provided in 42 CFR 417.528). 42 CFR 417.454(a)**	**[ ] MET [ ] NOT MET**			
MK01b	**If the MCO offers its Medicare enrollees an optional supplemental benefit plan which includes charges for deductible and coinsurance amounts or noncovered services, or both, then the portion of the premium for coinsurance and deductibles applicable to covered services is computed separately and is disclosed to the Medicare beneficiary/applicant before he or she elects coverage options. The sum of the amounts the MCO charges its Medicare enrollees for noncovered services under Part A or Part B may not exceed the ACR as annually approved by HCFA.** **42 CFR 417.452(d)**	**[ ] MET [ ] NOT MET**			
MOE	**Benefits Review:** As part of the marketing section of the review, review the Medicare benefits package(s) to ensure the following: ☞At least the MCO's Basic Benefit Package, as presented in the MCO's approved ACRP and BIF, is marketed throughout the MCO's entire HCFA-approved service area. To do so: ❑ Request and review onsite specific marketing materials and EOCs for EACH COUNTY in the HCFA-approved service area to ensure that the basic benefit package is available throughout this area. ❑ If possible, attend a marketing presentation / demonstration and ensure that all Medicare and MCO-contracted benefits are available and offered by the MCO. ❑ Obtain a copy of newspaper ads or other media announcing the open enrollment period; **and review materials to ensure compliance.** ❑ For MCOs that have continuous open enrollment, verify that they periodically advertise the availability of their MCO by newspaper, radio, TV, or direct mail; ❑ For MCOs that have open enrollment periods, the MCO must advertise during the open enrollment period throughout the service area, using mass media, such as newspapers, radio, or television. For MCOs with closed enrollment/enrollment capacity waivers, the MCO adheres to the terms of the capacity waiver; ❑The basic benefit package is marketed in at least ONE county; other "flexed" benefit products may be flexed by county until December 31, 1998.				

MOE cont.	☞That Optional Supplemental Benefit (OSB) packages are offered throughout the entire HCFA-approved Medicare contract geographic area. REMEMBER: All benefits must be made available to all Medicare beneficiaries at the time of initial enrollment. To do so: ❑ Request and review specific marketing materials for EACH COUNTY where the MCO offers OSB packages. ❑ Review the MCO benefit file to determine the counties where the MCO must offer the approved ACR product. This file will also indicate if the MCO has been approved to make any "mid-year" changes to the benefit package. Reviewers should determine that approved changes, if any, are offered to all members. REMEMBER: mid-year benefits must be clearly advantageous to the beneficiary (e.g., lowering member cost sharing; providing additional benefits) and must be made available to all currently enrolled and prospective Medicare beneficiary enrollees throughout the contract area.			
MK02	**The MCO publicizes the annual open season and all enrollment periods, whether of limited or continuous duration, through appropriate media. The MCO has at least one continuous 30-day open enrollment period annually.** **42 CFR 417.428(a)(2) and 42 CFR 417.426(a)** **[ ] MET [ ] NOT MET**			
MOE	**Determine and/or Review:** ❑ The MCO's marketing strategy for the Medicare product and projected enrollment growth through interviews with marketing personnel. ❑ The MCO's marketing reference sources such as the marketing/advertising plan, trainer's manual, and bulletins discussing coverage and rules for accuracy of presentation of the Medicare contract (e.g., lock-in, access to emergency or urgently needed out-of-area care properly explained). ❑ The accuracy and completeness of information presented by attending a training session for new marketing representatives or a marketing presentation to prospective enrollees.			
MK03	**The MCO must provide a current copy of their Evidence of Coverage (EOC) that clearly describes member rights and rules to enrollees at the time of enrollment and annually thereafter.** **42 CFR and 417.436(a) and (b); HMO/CMP Manual Section 2002; National Marketing Guidelines** **[ ] MET [ ] NOT MET**			
MOE	● The MCO must provide, and be able to substantiate the release date of, a current copy of the EOC. The MCO must provide a current copy of their evidence of coverage (EOC) that clearly explains member rights, responsibilities and rules to enrollees at the time of enrollment and annually thereafter. This EOC must include requisite language pertaining to the following (pursuant to review of EOC, check all that are found in EOC): ❑All benefits provided, including benefits offered under a point-of-service (POS) benefit, if applicable. If the MCO offers an extension of membership through an affiliation agreement, confirm that the MCO clearly defines the affiliate option (OPL 96.042), including an unambiguous statement that an affiliation agreement is not a benefit; it is an extension of membership. Cross-check benefits specified in the EOC to the BIF to confirm integrity of benefit package;			

MOE cont..	❑How and where to obtain services, including specific instructions for any POS benefit; ❑Restrictions on coverage; ❑Normal and expedited appeals procedures ❑Advance directives; ❑Disenrollment rights as well as voluntary and involuntary disenrollment procedures; ❑Grievance procedures; ❑Definition of emergency service/care, out-of-area urgently-needed service/care, POS benefit (if applicable) as well as explanation regarding the obligation of the MCO to assume financial responsibility and provide reasonable reimbursement for emergency services, out-of-area urgently needed services, and any POS services specified. Review language explaining procedures for filing claims for such services; ❑Explanation of lock-in; ❑Beneficiary liability for premiums, co-payments, and the requirement that Medicare Part B premiums continue to be paid in addition to any other MCO liabilities; ❑The MCO premium and benefit package may change at the beginning of each contract period, but may not change during the contract period unless the change is to the advantage of the member, and must be sent in the form of written notice at least 30 days before the effective date; ❑The MCO or HCFA may terminate or refuse to renew the contract; ❑Coordination of benefits; ❑Moves and extended absences for members who leave the geographic area for more than 90 days, and any affiliate option offered by the MCO. **Determine:** ❑ How the MCO apprises Medicare beneficiary enrollees of the role of the peer review organization (PRO) and peer review system (generally this will be the EOC). Review MCO materials to determine if the MCO provides the name, address, and telephone number of the local PRO, along with instructions specifying how and under what circumstances, enrollees can contact the PRO. This information must be clearly and prominently displayed in member materials. ❑ Whether the MCO notifies its enrollees of changes in plan rules at least 30 days before their effective date by reviewing the Regional Office HMO/CMP marketing files for notices that describe changes (e.g., changes in provider network, benefit changes)			
MK04	**Application forms are submitted to HCFA for approval prior to use and comply with HCFA instructions regarding format and content.** **42 CFR 417.430(a); HMO Manual § 2001.5and Exhibit 1, §2099(1);** **[ ] MET [ ] NOT MET**			
MOE	• **Review:**❑ The application form and determine if it includes the applicant's name, sex, residence address, Medicare claim number, effective dates of entitlement to Parts A and B, information regarding whether the applicant has End Stage Renal Disease (ESRD) or is in a Medicare-certified hospice. Information as to whether the enrollee has Medicaid or has institutional status accompanied by a disclaimer that this information is not being used for health screening purposes or to deny the application. In addition an authorization must be included for disclosure and exchange of information between HCFA and the MCO through a statement similar to HCFA-recommended language. **RISK MCOs ONLY:** In addition to the above, the application form must contain an explanation of lock-in requirements and require that applicants acknowledge such understanding. • **Interview:** ❑ Staff responsible for processing Medicare applications and associated marketing activities, if necessary. **See also the model Application Form in HMO Manual under Exhibit 1, § 2099 (citation subject to change)**			

MK05	**The MCO does not engage in activities which mislead, confuse, or misrepresent (e.g., MCOs may not claim recommendation or endorsement by HCFA or that HCFA recommends that the person enroll in the organization; MCOs may not make erroneous written or oral statement including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in HCFA-approved materials).** **42 CFR 417.428(b)(2); National Marketing Guidelines [ ] MET [ ] NOT MET**			
MK06	**The MCO does not offer gifts or payment as an inducement to enroll in the organization.** **42 CFR 417.428(b)(3); National Marketing Guidelines [ ] MET [ ] NOT MET**			
MK07	**The MCO does not conduct door-to-door solicitation of Medicare beneficiaries.** **42 CFR 417.428(b)(4); National Marketing Guidelines [ ] MET [ ] NOT MET**			
MOE	• **Review:** The MCO's oversight of its marketing representatives to determine: ❑ How the MCO exercises management control over its agents, including those who are not employees; ❑ What procedures are in place to test staff's understanding of the Medicare program; and ❑ What procedures are in place to monitor the activities of the marketing staff. ❑ Marketing To Individuals Whose Entitlement To Medicare Is By Way of Disability. Determine if the MCO has developed and maintained a marketing program -- or a discreet component of its overall Medicare marketing program -- for disabled individuals who are entitled to Medicare. ❑ Personnel evaluations to determine where marketing emphasis is placed, i.e., numbers enrolled versus accuracy of enrollments. ❑ Review MCO files for sales agents' licenses (where required by state). **NOTE:** While these regulations do prohibit door-to-door solicitation, they do not prohibit telemarketing activities intended to generate marketing leads. MCOs may utilize calling lists to generate "cold calls" to prospective enrollees, provided the MCOs do not otherwise violate the prohibition on door-to-door solicitations. If there are enrollee complaints about marketing representatives or other indicators of potential marketing problems (e.g., new procedures or incentive programs), check marketing staff personnel files to determine: ❑ If the MCO keeps a record of disenrollments in each representative's file; ❑ If there is a charge-back to the agent in each case where the enrollee disenrolled within 3 months of being enrolled;			

MOE cont..	❑ If agents with high disenrollment rates are subjected to supervisory review or disciplinary actions; and ❑ If there is any record of feedback or disciplinary action in the agent's file. • **Interview:** Marketing personnel, and/or CEO/executive director, and/or Medicare coordinator. Reviewer has discretion to interview all or any combination of MCO marketing officials that they determine to be sufficient to glean necessary information.			
	ONGOING MARKETING REVIEW			
MK08	**The MCO submits all Medicare marketing materials (e.g., ads, brochures, enrollment and disenrollment notices, subscriber agreements, and other marketing material including those prepared by contracting third parties) to HCFA at least 45 days before their planned distribution.** **42 CFR 417.428(a)(3)** **[ ] MET [ ] NOT MET**			
MK09	**The MCO does not distribute Medicare marketing materials if, before the expiration of the 45-day period, it receives written notice from HCFA that HCFA has disapproved the material because it is inaccurate or misleading, or it misrepresents the organization, its marketing representative, or HCFA.** **42 CFR 417.428(b)(5)** **[ ] MET [ ] NOT MET**			
MOE	**Ongoing Marketing Review:** MCOs that have Submitted Materials Within the Prior 6-Month Time Period: The Regional Office marketing/member material review process is an ongoing process that takes place somewhat continuously, beginning when the MCO receives HCFA approval to offer a managed care product to beneficiaries. Therefore, it may not be necessary for reviewers to undertake a separate review of marketing/member materials at the time of each performance review. However, for purposes of the monitoring review, the reviewer should review the results of this ongoing review process to determine if the MCO meets applicable regulatory requirements. ❑ Request that the MCO review and summarize the materials submitted during the prior 6 month period before the monitoring visit. If the Regional Office maintained a "log" detailing prior marketing material reviews, this individual review of materials may not be necessary. MCOs that have NOT Submitted Materials Within the Prior 6-Month Time Period: While onsite, review MCO marketing materials, including enrollment and disenrollment letters and notices, claims notices, and other marketing materials obtained from the review of other samples (e.g., letters prepared by third parties such as contracting medical groups and /or doctors). Review for accuracy and completeness of information, including lock-in for risk-based contractors, definition of emergency and urgently needed care, Medicare appeals, and grievance language. Utilize the National Marketing Guidelines.			